NAME: _____ **RECORD #:** _____

_____'s Plan

Plan Meeting Date: _____

For Plan Approver Only
Plan Approved By: _____
Plan Approved Date: ___ / ___ / _____

Name (As appears on Medicaid Card)	**Preferred Name**
Area Program	**Case Manager**
Record Number / Unique ID	**Date of Birth**
Address	**Phone**
City, State, Zip	**Medicaid County**
Social Security Number	**Medicaid ID#:**
Gender: ☐ **Female** ☐ **Male**	**Medicare/Insurance**

Race/Ethnicity: ☐ White ☐ African Am ☐ Hispanic ☐ Native Am ☐ Asian ☐ Other

TYPE
☐ Initial Plan
☐ Continued/Update
☐ Transition

CAP-MR/DD
☐ At Risk for ICF/MR Placement
☐ Previously in an ICF-MR bed

SPECIAL FUNDING
☐ MR/MI
☐ At Risk Children
☐ Other (Specify) _____

RESIDENCY
☐ Private home with natural family
☐ Individual Residence
☐ Supervised Living _____# of consumers
☐ Adult Care Home _____# of consumers
☐ Child Foster Care
☐ AFL /Therapeutic Home
☐ ICF-MR
☐ Other (Specify) _____

☐ NC-SNAP Score _____ ☐ LOS _____

CONTACT PERSON

☐ **Next of Kin/ Relationship**

☐ **Legally Responsible Person**

Type:

Date of Action:

Name:

Address:

City/State/Zip:

Phone (home):

Phone (work):

PARTICIPANTS IN PLAN DEVELOPMENT

NAME: _____ RECORD #: _____

Medical Information

Date Completed _____

	CODE	DIAGNOSIS	Indicate Primary Diagnosis with "P"
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			

MEDICATION	DOSAGE & ROUTE	SCHEDULE	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME: _____ **RECORD #:** _____

What has happened in _____ life this past year (or if new plan, within the last few years)? What goals have been met?
What does _____ want his/her life to be like? What is important? What are his/her goals?

NAME: _____ **RECORD #:** _____

	Based on the person's developmental, functional, physical and psychiatric status, what in his/her treatment or intervention routine makes sense/doesn't make sense?	
	A. What are the person's strengths and preferences? B. What needs to be maintained/enhanced in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?	A. What are the person's problems and needs? B. What needs to change or be different in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?
from his/her perspective:		
from other people's perspective:		

What do we need to know or do to support _____?

NAME: _____ **RECORD #:** _____

Action Plan

This actions plan is developed to help _____ meet his/her goals through addressing what needs to change and needs to be maintained as identified on the previous pages.

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	**HOW**	**WHO'S RESPONSIBLE**	**BY WHEN**	**SERVICE AND FREQUENCY**

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	**HOW**	**WHO'S RESPONSIBLE**	**BY WHEN**	**SERVICE AND FREQUENCY**

(Repeat page as necessary)

NAME: _____ **RECORD #:** _____

Case Management/Service Monitoring Plan

TYPE		FREQUENCY / CONTACT SCHEDULE
Face to Face:	Individual Family / Guardian Provider(s)	
Collaterals:	Individual Family / Guardian Provider(s) Education Others (residential/ vocational, etc.)	
	Service Observations / Visits Review of Service Documentation Review of Outcomes/Supports Strategies Review of Paid Claims Information Review of CM Indicator on Medicaid Card	
Other / Comments		

Attached are the following documents (check all that apply):

- NC-SNAP (required for new and renewal) ☐
- MRMI Level of Supports ☐
- Staff Privileging/Training plan ☐
- Crisis Plan ☐
- Behavior Plan ☐
- Advanced Health/Mental Health Directive ☐
- Justification for Equipment or Supplies ☐
- Individual Education Plan (IEP) ☐
- Assessment of Personal Outcomes and Supports ☐
- Individual and Family Service Plan ☐
- Other (Explain) ☐

DATES OF QUARTERLY REVIEWS (IF REQUIRED)	

NAME: _____ **RECORD #:** _____

Signatures

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

Title	**Name / Signature**	**Date**
Individual		
Family Representative/ Legal Guardian		
Case Manager		
Single Portal Representative		
LEA Representative		
Clinician		

For CAP-MR/DD Funded Consumers Only:

1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.
2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
3) I understand that I have the choice of service providers and may change service providers at anytime by contacting my case manager

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

NAME: _____ **RECORD #:** _____

Plan Update/Revision

Implementation Date: _____

What has happened in _____ 's life (personal or clinical) to cause the need for revision?

	Based on what is important to the person, the person's goals, and the person's clinical status, what in his/her life makes sense and what does not make sense?	
	A. What are the person's strengths & preferences? B. What needs to be maintained/enhanced in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?	A. What are the person's problems and needs? B. What needs to change of be different in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?
from his/ her perspective:		
from other people's perspective:		

(Attach update NC-SNAP if there are changes)

What do we need to know or do to support _____differently?

_____ **DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME # BASED ON WHAT DOES/DOES NOT MAKES SENSE, INCLUDING METHOD OF EVALUATION:** _____

WHAT	HOW	WHO'S RESPONSIBLE	BY WHEN	SERVICE & FREQUENCY

Required Signatures: The following confirms the involvement of the individual / guardian in the update of this plan including revision to the cost summary.

Individual: _____ **Date:** _____

Legally Responsible Person: _____ **Date:** _____

Case Manager _____ **Date:** _____

_____ **Date:** _____